Commonwealth of Massachusetts, Department of Public Health, Division of Food and Drugs
305 South Street, Jamaica Plain, MA 02130
Telephone 617 983-6700 Fax 617 524-8062
Application for Massachusetts Controlled Substances Registration for a Community Program
In Accordance with the Controlled Substances Act, M.G.L. Chapter 94C

Please be sure to:
- Complete the application form
- Sign (not initial) and date form
- Mail to the address above

Incomplete applications will be returned and will cause a delay in receiving your MCSR. Where photocopied documents are to be submitted along with your application, do not send originals. They will not be returned.
For further information visit our Web site at http://www.mass.gov/dph/dcp.

Application Type: (Please select one) ❑ New ❑ Renewal ❑ Amended Information

In the boxes below enter the requested information.

1) Classification: (Select one)

○ DMH ○ DMR ○ Other

Submit a photocopy of your license(s) or certificate(s) or the front page copy of your contract with DMH or DMR with this application.

2) State Operated:

○ Yes ○ No

3) Service Provider Business Name:

4) Service Provider Business Address:

5) Service Provider Mailing Address: (If different)

6) Service Provider Telephone No.: ( ) area code

7) Site Address: (Applications that include a P.O. Box number without a street address cannot be processed.)

8) Program Director Name:

9) Program Director Supervisor Telephone No.: ( ) area code

10) If a renewal, current Mass. Controlled Substance Registration No.:

11) Fax No.: (Optional) ( ) area code

12) E-mail: (Optional)

13) Type Of Site: (Check all that apply.)

❑ Individual Apartment	❑ Employment & Training	❑ Day Program
❑ Shared Apartment	❑ Short-Term Respite	❑ Work Program
❑ Staffed Apartment	❑ Group Home/Residence	❑ Other:
❑ Supportive Housing	❑ ACT Program	Specify:

14) Population(s): (Check all that apply.)

❑ Adults (18 years of age or older)t	❑ Minors (under 18 years of age)	❑ Both

I hereby certify that the information on this application is true to the best of my knowledge, and that the applicant will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health. I also certify, in accordance with M.G.L. c. 62C, s. 49A, that the applicant has to the best of my knowledge and belief filed all state tax returns and paid all state taxes required under law.

Signed under the pains and penalties of perjury.

Signature of authorized individual _____ Date _____
Authorized Individual

Print Name: _____

Title: _____